BEFORE THE
PHYSICAL THERAPY BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	Case #: 1D 2000 62592
	)	
	)	OAH No.: L 2002 120757
JANE E. SAVAHELI	)	
	)	
	)	
	)	

The foregoing Proposed Decision, in case number 1D 2000 62592, is hereby adopted by the Physical Therapy Board, Department of Consumer Affairs, State of California.

This decision shall become effective on the 3rd day of June, 2004.

It is so ordered this May 4, 2004 .

Original Signed By:
Don A. Chu, P.T., President
Physical Therapy Board
of California

BEFORE THE
PHYSICAL THERAPY BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the First Amended Accusation Against: JANE E. SAVAHELI P.O. Box 491103 Los Angeles, California 90049, Physical Therapist's License No. PT-9186, Respondent.	Case No. 1D-2000-62592 OAH No. L-2002120757

PROPOSED DECISION

This matter was heard by Vincent Nafarrete, Administrative Law Judge of the Office of Administrative Hearings, at Los Angeles on February 23 and 24, 2004. Complainant was represented by E. A. Jones III, Deputy Attorney General. Respondent Jane E. Savaheli was present throughout the hearing and represented by Edward O. Lear, Attorney at Law.

During the hearing, the record was held open for complainant to file a revised cost certification. On February 27, 2004, the Revised Certification of Investigation Costs was received and admitted into evidence as Exhibit 25.

Oral and documentary having been received, the Administrative Law Judge submits this matter for decision on February 27, 2004, and finds as follows:

FACTUAL FINDINGS

1. The Administrative Law Judge takes official notice that, on June 17, 2003, the First Amended Accusation, Case No. 1D-2000-62592, was made and filed by Steven K. Hartzell in his official capacity as Executive Director of the Physical Therapy Board of California, Department of Consumer Affairs, State of California (hereinafter Board).

2. On or about June 22, 1979, the Board issued physical therapist's license no. PT-9186 to Jane E. Savaheli (hereinafter respondent). Said certificate expires on July 31, 2005, and is in full force and effect. Respondent has no prior disciplinary history.

3. Respondent obtained her bachelor's degree in physical therapy from McGill University in Montreal, Canada, in or about 1978. She then moved to California and began working at Valley Presbyterian Hospital under the supervision of a licensed physical therapist before receiving her own license. Respondent was then hired by Chino Community Hospital to supervise the physical therapy department and organize a cardiac rehabilitation unit. In 1980, she became the director of physical therapy at Midway Hospital in Los Angeles where she formed the physical department and directed the physical therapy applicant program. As director, respondent supervised 15 employees and provided training and reviews of documentation and record-keeping practices of physical therapists, applicants, and other employees. In 1986, she entered the private practice of physical therapy and opened Academy Rehabilitation and Sports Physical Therapy in Santa Monica.

4. Respondent has been the sole licensed physical therapist at Academy Rehabilitation and Sports Physical Therapy since its inception. As the licensed physical therapist, she has been responsible for providing care and treatment to patients, documenting the therapy in the patients' medical charts and records, and supervising physical therapy aides. Her husband is the legal owner of Academy Rehabilitation and has been responsible for managing the business affairs of the physical therapy clinic.

5. (A) In or about July 2000, the Board received a consumer complaint from one of respondent's patients and started an investigation. In May 2001, a senior investigator for the Board and the expert reviewer in this matter went to the clinic of Academy Rehabilitation in Santa Monica to review physical therapy records. Respondent was not present at that time. She had been renting office space from a physician at that location for approximately 16 months and her rental arrangement was ending in two months.

(B) On July 3, 2001, the investigator and expert reviewer returned to the Academy Rehabilitation clinic where they spoke to respondent and conducted an inspection of a random selection of patients' physical therapy records. On August 8, 2001, the investigator sent third party notification letters to those patients, asking for authorizations for the releases of their medical records from respondent's office. Subsequently, the investigator received authorizations for release of medical records from four patients, served an investigative subpoena upon respondent for copies of physical therapy treatment and billing records for five patients, and received medical records for other patients from respondent. In addition, the Board received copies of the medical records, including billing records, of patient HZ from respondent and billing records and other documents from patient HZ's attorney.

(C) On January 30, 2001, the Board's expert reviewer issued a report of his review of documents pertaining to patient HZ. On February 25, 2002, the expert reviewer completed a written review of the medical records of several other patients. On November 27, 2002, the original accusation in this matter was issued. On December 6, 2002, respondent filed a Notice of Defense, requesting a hearing in this matter. On June 17, 2003, the instant amended accusation was issued.

PATIENT LT

6. (A) On or about March 5, 1999, patient LT was referred by his physician to Academy Rehabilitation and respondent for a physical therapy evaluation and treatment for two to three weeks. He had fallen on his hip and been diagnosed with lumbar disc disease and tronchanteric bursitis. Patient LT complained to respondent of pain in his right hip and buttock which radiated to his lateral thigh and reported prior surgeries on his right knee, scoliosis, and long-term, low back pain.

(B) Respondent observed the patient's scoliosis with his right pelvic crest elevated and noted his right leg was longer by one-half inch. Respondent measured his range of motion and strength and found tenderness and spasms on palpation. Patient LT indicated that he was an avid tennis player, golfer, and bicyclist and that his pain limited his activities. Respondent noted that the goals for physical therapy were to decrease pain and inflammation and improve his functions so that he may be able to resume his activities. Her physical therapy treatment plan for the patient was to administer hot packs, ice, phonophoresia, medical exercise therapy, and soft tissue and joint mobilization.

(C) Beginning on March 5, 1999 and ending on April 2, 1999, patient LT received physical therapy at Academy Rehabilitation on approximately 11 occasions over the four week period. Physical therapy was provided to the patient by a physical therapy aide and by respondent.

7. (A) For the initial physical therapy evaluation of patient LT on March 5, 1999, respondent did not adequately document her evaluation or treatment goals in the patient's chart or record. In the written initial evaluation, respondent noted that the goals for physical therapy were to decrease pain and inflammation and to improve function. However, respondent failed to note an objective or subjective measurement or scale of the patient's level of pain or inflammation that existed at the time of the initial evaluation. A physical therapist should note such measurement or scale of the patient's pain or inflammation at the time of initial evaluation in order to monitor the patient's progress under physical therapy and to be able to summarize treatment or make recommendations for discharge from therapy. Respondent did not sign the initial evaluation contained in the patient's chart.

(B) In addition, for patient LT's subsequent therapy sessions through April 2, 1999, respondent did not adequately document or cause the physical therapy aide to adequately document the treatment plan and summary of treatment in the patient's chart or record. For each of the therapy sessions in the progress record, respondent and her aide failed to specifically describe the frequency, duration, and intensity of the therapies administered to patient LT or the responses of the patient to the therapies.

(C) Based on Findings 6, 7(A) – (B) above, respondent's failure to note measurements of pain and inflammation at the initial visit rendered the initial evaluation and report to be incomplete under Business and Professions Code Section 2620.7. Her failures to document the frequency, duration, or intensity of therapies administered to the patient or

the patient's responses to the therapy rendered her progress record to be likewise incomplete under Section 2620.7.

(D) It was not established that, on or about January 10, 2000, respondent again saw and evaluated patient LT at her office and clinic. No evidence or medical records were presented regarding an office visit or evaluation on January 10, 2000. The expert's brief summary of such records was not sufficient proof of any incomplete charting under Business and Professions Code Section 2620.7.

8. On the treatment dates of March 10, 12, 19, 24, 29, 31, and April 2, patient LT received physical therapy treatment from a physical therapy aide who was employed by Academy Rehabilitation and not licensed by the Board. On said dates, the physical therapy aide administered or provided patient LT with hot packs, soft tissue and joint mobilization, and phonophoresis. Said aide noted the physical therapy services or treatment that she provided to the patient on each of these days in the patient's progress record but did not sign the daily progress notes or progress record as required by Title 16, California Code of Regulations (16 CCR), Section 1399(b)(2). In addition, respondent did not countersign and date the entries by the aide on the same day that the aide provided physical therapy services to the patient.

9. (A) On patient LT's treatment dates of March 10, 12, 19, 24, 29, 31, and April 2, 1999, the physical therapy aide rendered physical therapy services directly to patient LT and thus performed patient related tasks to patient LT within the meaning of Business and Professions Code Section 2630 and 16 CCR Section 1399.

(B) After the initiation of care and on said seven treatment dates that the physical therapy aide rendered physical services directly to patient LT, respondent determined the patient related tasks assigned to be performed by the aide as set forth in the progress record but then failed to provide continuous and immediate supervision of the aide. Based on the progress record, on said dates that the aide provided patient related tasks to LT, respondent did not at any point during said treatment days provide direct service to the patient as treatment for the patient's condition or further evaluate or monitor the patient's progress, for respondent did not enter any contemporaneous notes in the progress record of any such service, evaluation, or monitoring. Respondent did not continuously and immediately supervise the aide in that respondent did not ensure that the aide signed her progress notes and respondent did not countersign the aide's progress notes.

(C) On said seven treatment dates, respondent failed to ensure that the physical therapy aide was at all times under her orders, direction, or immediate supervision in violation of Business and Professions Code Section 2630 and 16 CCR Section 1399. As such, respondent permitted the aide to independently perform physical therapy on patient LT on those seven treatment dates

10. (A) Based on Findings 6 – 9 above, respondent aided or abetted the physical therapy aide to violate provisions of the Physical Therapy Practice Act or regulations adopted thereunder.

(B) Based on Findings 6 – 9 above, respondent aided or abetted the physical therapy aide to engage in the unlawful practice of physical therapy.

11. (A) On the seven treatment dates that the aide rendered physical therapy services directly to patient LT, respondent failed to make any notes contemporaneously in the patient's progress record. Only the aide entered progress notes on said dates although the aide did not sign her notes.

(B) On July 3, 2001, the Board's expert reviewed the chart and progress record of patient LT while at respondent's office and clinic at Academy Rehabilitation. The expert observed that on the treatment dates of March 10, 12, 19, 24, 29, 31, and April 2, 1999, the progress notes and record did not contain any entries, notations, or signatures by respondent. Respondent told the expert that the aide had provided the treatment to the patient on these dates.

(C) Four months later, on or about November 1, 2001, respondent provided the physical therapy records of patient LT to the Board's investigator pursuant to the subpoena. The expert reviewed the physical therapy records and found that respondent had entered notes and her signatures in the progress record for patient LT for the dates of March 10, 12, 19, 24, 29, 31, and April 2, 1999, without indicating or signaling in any manner that these notes and signatures were added to the progress record after the physical therapy was completed and after the dates of treatment. In other words, respondent added her notes and signatures to the patient's progress record after July 3, 2001, and before providing the chart to the Board in November 2001 in such manner to make it appear that her added notes and signatures were entered contemporaneously with the treatment by the aide.

(D) Based on Findings 6 – 9 and 10(A) – (C) above, respondent committed fraudulent or dishonest acts by adding to or altering the physical therapy records of patient LT without indicating that her additions or alterations were done subsequently or after the treatment dates. Her fraudulent or dishonest acts were substantially related to the qualifications, functions, or duties of a licensed physical therapist.

12. (A) For the treatment dates of March 10, 12, 19, 24, 29, 31, and April 2, 1999, respondent submitted billing claims to patient LT's health care insurer for payment of physical services rendered. Respondent submitted the claims to the insurer without noting that the physical therapy services were provided by an aide rather than by a licensed physical therapist.

(B) It was not established, however, that respondent's billing claims were fraudulent, dishonest, or corrupt acts just because the physical therapy services were provided to the insured patient by a physical therapy aide rather than a licensed physical

therapist. No evidence was presented that there were other codes for billing services of an aide or other billing codes that respondent could have used to receive payment for physical therapy services performed by an aide instead of a physical therapist. No evidence was presented that respondent was required to denote on the billing claims that services were provided by other than a physical therapist.

PATIENT WB

13. It was not established that, beginning on or about April 26, 1999, and continuing for undetermined number of sessions until on or about May 7, 1999, respondent aided and abetted an occupational therapist to violate the Physical Therapy Practice Act or regulations thereunder or to engage in the unlawful practice of physical therapy.

14. The progress record or physical therapy chart of patient WB was not available and not provided to the Board because respondent was unable to locate the chart. The only evidence that patient WB was treated by the occupational therapist was the testimony and report of the Board's expert. Yet, the expert did not explain why he believed that the occupational therapist provided the physical therapy services to the patient or why he believed that respondent allowed the occupational therapist to practice physical therapy. Unlike the treatment for patient LT, no probative evidence was presented that the occupational therapist entered notes in the chart or respondent allowed the occupational therapist to provide services to the patient without continuous and immediate supervision.

PATIENT AC

15. (A) On February 10, 2000, patient AC was referred by her physician to Academy Rehabilitation for an evaluation and physical therapy for tendonitis in the rotator cuff of her right shoulder. Patient AC presented to respondent with complaints of pain, stiffness, and reduced function in her right shoulder and pain in the left side of her neck. Respondent palpated the patient and measured the range of motion and strength of her right shoulder. Respondent noted that the patient was suffering from sleeplessness, reduced activities of daily living, and reduced lifting and reaching with her arm. With respect to the goals for physical therapy, respondent indicated that she wanted to decrease the patient's pain, spasm levator scapulae, and inflammation and wanted to increase the patient's range of motion and function. Respondent's treatment plan for patient AC consisted of hot packs, ice, phonophoresis, soft tissue and joint mobilization, medical exercise therapy, and shoulder rehabilitation.

(B) For the initial physical therapy evaluation of patient AC on February 10, 2000, respondent did not adequately document her evaluation or treatment goals in the patient's chart or record. In the handwritten and typed initial evaluations, respondent noted that the goals for physical therapy included the decrease of pain and inflammation. However, respondent failed to note any objective or subjective measurement or scale of the patient's

level of pain or inflammation that existed at the time of the initial evaluation. Respondent failed to adequately document her initial evaluation of patient AC.

16. On eight occasions from February 10, 2000, until March 15, 2000, respondent provided physical therapy to patient AC as described in her treatment plan. For each of these sessions, respondent noted in the progress record the physical therapy modalities that she rendered to the patient and made other notes such as whether the patient improved, experienced pain, and was provided additional therapy services. However, for the eight sessions, respondent did not specifically describe the frequency, duration, and intensity of the therapies provided to patient AC and did not note the responses of the patient to the therapies in the progress record. Respondent did not adequately document the treatment plan and summary of treatment in the patient's chart or record.

17. On March 15, 2000, patient AC presented for her last visit and respondent added a treatment modality, provided physical therapy services pursuant to the treatment plan, and reviewed all of the therapies provided during the course of treatment. On said date, respondent prepared a written progress update in which she described the patient's progress under physical therapy, current goals, and recommendations. In the progress update, respondent noted that the patient experienced a reduction in pain and discomfort, resolved her spasm and neck pain, increased her range of motion, and strengthened her rotator cuff by two pounds of resistance. As such, respondent referenced the goals of the initial evaluation. Respondent's progress update constituted a discharge summary and an adequate summary of treatment.

18. Based on Findings 15 – 16 above, respondent's failure to note measurements of pain and inflammation at the initial visit rendered the initial evaluation and report to be incomplete under Business and Professions Code Section 2620.7. Her failures to document the frequency, duration, or intensity of therapies administered to the patient or the patient's responses to the therapy rendered her progress record to be likewise incomplete under Section 2620.7. It was not established that respondent's discharge summary was inadequate or incomplete.

PATIENT JH

19. (A) On April 30, 1999, patient JH was referred to Academy Rehabilitation for evaluation and physical therapy to treat trochanteric bursitis of the right hip. Patient JH complained of constant pain in the right lateral hip and anterior thigh. Upon palpation, respondent noted acute tenderness and piriformis spasms. Respondent measured the patient's range of motion and reactions to resisted motion. In her initial evaluation, respondent stated that the goals for physical therapy were to decrease pain, spasms, and inflammation and to restore function and pain-free activities of daily living. The treatment plan was to consist of hot packs, phonophoresis, soft tissue and joint mobilization, and medical exercise therapy.

(B) On the initial evaluation report, respondent did not adequately document her evaluation or treatment goals in the patient's chart or record. In the handwritten and typed initial evaluations, respondent noted that the goals for physical therapy included the decrease of pain and inflammation. However, respondent failed to note an objective or subjective measurement or scale of the patient's level of pain or inflammation that existed at the time of the initial evaluation. As such, respondent's initial evaluation and treatment goals for patient JH were not complete.

20. On four sessions from April 30, 1999, until May 14, 1999, respondent provided physical therapy to patient JH as described in her treatment plan. For each of these sessions, respondent noted in the progress record the physical therapy modalities that she rendered to the patient. However, for each of the four sessions, respondent did not specifically describe in the progress notes the frequency, duration, and intensity of the therapies provided to patient JH and did not note the responses of the patient to the therapies. As such, the progress record for the patient was not completely documented.

21. Based on Findings 19 – 20 above, respondent's failure to note measurements of pain and inflammation at patient JH's initial visit rendered the initial evaluation and report to be incomplete and inadequately documented under Business and Professions Code Section 2620.7. Her failures to document the frequency, duration, or intensity of therapies administered to the patient JH or the patient's responses to the therapy rendered her progress record to be likewise incomplete and inadequately documented under Section 2620.7.

PATIENT DG

22. (A) On May 29, 1998, patient DG presented to respondent at Academy Rehabilitation for physical therapy on referral from her physician. As documented in the Patient Initial Evaluation, patient DG complained of pain in her left thigh, constant discomfort and pain with any left hip flexion, and difficulty in walking due to loss of balance and dizziness. Respondent measured the patient's pertinent range of motion and strength of her left hip. Respondent noted that goals of physical therapy would be to decrease her left thigh pain and spasm or swelling, increase the range of motion of her left knee and strength of her left hip, and improve balance and functions of activities of daily living. The treatment plan was to consist of hot packs, manual mobilization and strengthening, medical exercise therapy, and balance and vestibula training.

(B) On the initial evaluation report, respondent did not adequately document her evaluation or treatment goals in the patient's chart or record. In the typed initial evaluation, respondent noted that the goals for physical therapy included the decrease of pain and swelling. However, respondent failed to note an objective or subjective measurement or scale of the patient's level of pain or swelling that existed at the time of the initial evaluation. As such, respondent's initial evaluation and treatment goals for patient JH were not complete.

23. Respondent provided physical therapy to patient DG on May 29 and June 5, 1998, pursuant to her treatment plan. For each of these two sessions, respondent noted in the progress record the physical therapy modalities that she provided to the patient. However, respondent did not specifically describe the frequency, duration, and intensity of the therapies provided to patient DG and did not note the responses of the patient to the therapies in the progress record. In addition, respondent did not prepare a discharge summary for patient DG on completion of physical therapy. The letter addressed to the referring physician and dated May 29th was not a discharge summary. As such, respondent's progress notes for patient DG"s physical therapy sessions were not complete and respondent did not adequately document the treatment plan and summary of treatment in the patient's chart or record.

24. Based on Findings 22 – 23 above, respondent's failure to note measurements of pain and swelling at patient DG's initial visit rendered the initial evaluation and report to be incomplete and inadequately documented under Business and Professions Code Section 2620.7. Her failures to document the frequency, duration, or intensity of therapies administered to the patient JH or the patient's responses to the therapy and to prepare a discharge summary rendered her progress record to be likewise incomplete and inadequately documented under Section 2620.7.

PATIENT EN

25. (A) On November 29, 1999, patient EN presented to respondent at Academy Rehabilitation for an initial evaluation and physical therapy. According to the report of initial evaluation, patient EN complained of left knee pain and weakness and difficulty in walking and indicated she had fallen several times. Respondent observed that the patient used a cane and that her left quadriceps was atrophied. Respondent measured the range of motion and strength of the patient's left knee and extremity. The goals for physical therapy were to decrease pain and inflammation and increase strength. The treatment plan was to provide hot packs, ultrasound, soft tissue mobilization of the left knee, medical exercise therapy, and training in gait, balance, and proprioception.

(B) On the initial evaluation report, respondent did not adequately document her evaluation or treatment goals in the patient's chart or record. Respondent noted that the goals for physical therapy included the decrease of inflammation and pain. However, respondent failed to note an objective or subjective measurement or scale of the patient's level of swelling or pain that existed at the time of the initial evaluation. As such, respondent's initial evaluation and treatment goals for patient JH were not complete.

26. Respondent provided physical therapy services to patient EN on November 29, 1999, and at four more sessions ending on December 13, 1999. As set forth in the progress record, respondent provided physical therapy pursuant to the treatment plan and noted the treatment modalities in the chart as well as additional treatments. However, respondent did not specifically describe in the progress record the frequency, duration, and intensity of the

therapies provided to patient EN and did not note the responses of the patient to the therapies. In addition, respondent did not prepare or place in the chart a discharge summary for patient EN on completion of physical therapy. As such, respondent's progress notes for patient EN"s physical therapy sessions were not complete and respondent did not adequately document the treatment plan and summary of treatment in the patient's chart or record.

27. Based on Findings 25 – 26 above, respondent's failure to note measurements of pain and swelling at patient EN's initial visit rendered the initial evaluation report to be incomplete and inadequately documented under Business and Professions Code Section 2620.7. Her failures to document the frequency, duration, or intensity of therapies administered to the patient EN or the patient's responses to the therapy and to prepare a discharge summary rendered her progress record to be likewise incomplete and inadequately documented under Section 2620.7.

PATIENT CG

28. (A) On March 30, 1998, patient CG was referred by her physician to respondent and Academy Rehabilitation for an evaluation and to receive physical therapy procedures and modalities two to three times weekly for four weeks. On said date, respondent conducted an initial evaluation, prepared an initial evaluation report, and started the physical therapy regimen. According to the initial evaluation report, respondent noted the physician's diagnosis of adhesive capsulitis of the right shoulder and received the patient's complaints of pain and stiffness in the right arm, elbow, and hand and inability to lift the right arm. Respondent measured the patient's range of motion of her right shoulder; the patient's flexion and abduction of the right shoulder was limited by pain. The patient reported that all of her activities of daily life were limited by her shoulder condition. Respondent set the treatment goals to decrease pain, increase range of motion, and increase function of the right shoulder and arm. The treatment plan was to administer hot packs and ice, ultrasound, joint and soft tissue mobilization, and medical exercise therapy.

(B) With respect to her documentation of the initial evaluation, respondent did not adequately document her evaluation or treatment goals in the patient's chart or record. Respondent noted that the goals for physical therapy included the decrease of pain and increase of the range of motion. While she measured the patient's range of motion for the right shoulder, respondent failed to note an objective or subjective measurement or scale of the patient's level of pain that existed at the time of the initial evaluation. As such, respondent's documentation of the initial evaluation and treatment goals for patient CG was not complete.

29. Beginning on March 30, 1998, and continuing until April 26, 1998, respondent saw and treated patient CG for ten physical therapy sessions and made progress notes for these sessions. For each sessions, respondent noted or listed the treatment modalities provided the patient and a few impressions. However, respondent did not specifically describe in the progress record the frequency, duration, and intensity of the therapies

provided to patient CG and did not note the responses of the patient to the therapies. As such, respondent's progress notes for patient CG"s physical therapy sessions were not complete and respondent did not adequately document the treatment plan and summary of treatment in the patient's chart or record.

30. Based on Findings 28 – 29 above, respondent's failure to note measurements of pain and swelling at patient CG's initial visit rendered the initial evaluation report to be incomplete and the initial evaluation inadequately documented under Business and Professions Code Section 2620.7. Her failures to document the frequency, duration, or intensity of therapies administered to the patient EN or the patient's responses to the therapy likewise rendered her progress record to be likewise incomplete and the treatment inadequately documented under Section 2620.7.

31. It was not established that, on or about April 24, 1998, respondent failed to adequately document the summary of treatment in patient CG's chart. Respondent wrote and then typed a discharge summary which summarized the treatment provided and the patient's progress with reference to reduction of pain and the range of motion of her shoulder. The typed discharge is legible and constitutes documentation of the treatment.

32. It was not established that, on or after April 17, 1998, respondent committed a fraudulent, dishonest, or corrupt act by billing and receiving payment for physical therapy services that were not performed or provided to patient CG. The Board's expert wrote and testified that there were no progress notes for physical therapy services provided on April 17, 1998. However, the patient's chart does contain a progress note for April 17th which is in the correct chronological order and place in the physical therapy record. The April 17th progress note demonstrates that respondent did, in fact, provide therapy to the patient on that date.

PATIENT BW

33. (A) On February 11, 1998, patient BW was prescribed physical therapy for his resolving herniated disc by his physician. On February 16, 1998, patient BW presented to respondent and complained of pain in the lower back. Respondent conducted an initial evaluation during which she palpated the patient's back, measured range of motion, and noted the effects of the herniated disc on the patient's daily activities. As set forth in the written initial evaluation, respondent set the goals of physical therapy to decrease pain and muscle spasms, increase range of motion and daily functions, including walking, and return the patient to his independent exercise. Respondent's treatment plan consisted of administration of hot packs, soft tissue mobilization, range of motion, flexibility exercises, back rehabilitation, and work on activities of daily living.

(B) On February 16, 1998, respondent wrote and documented her initial evaluation of patient BW. Respondent did not adequately document her evaluation or treatment goals in the patient's chart. She noted that the goals for physical therapy included the decrease of pain and the increase of the range of motion and functions. While she measured the patient's

range of motion for his back or trunk and noted the patient's activities, respondent failed to note an objective or subjective measurement or scale of the patient's level of pain that existed at the time of the initial evaluation. As such, respondent's documentation of the initial evaluation and treatment goals for patient CG was not complete.

34. For fifteen sessions from February 16, 1998, until March 19, 1998, respondent provided physical therapy services and treatment to patient BW according to the treatment plan and made progress notes for these sessions. For each of the sessions, respondent noted or listed the treatment modalities provided the patient and other notes. However, respondent did not specifically describe in the progress record the frequency, duration, and intensity of the therapies provided to patient BW and did not note the responses of the patient to the therapies. As such, respondent's progress notes for patient BW"s physical therapy sessions were not complete and respondent did not adequately document the treatment plan and summary of treatment in the patient's chart or record.

35. Based on Findings 33 – 34 above, respondent's failure to note measurements of pain and swelling at patient BW's initial visit rendered the initial evaluation report to be incomplete and the initial evaluation inadequately documented under Business and Professions Code Section 2620.7. Her failures to document the frequency, duration, or intensity of therapies administered to the patient EN or the patient's responses to the therapy likewise rendered her progress record to be incomplete and the treatment inadequately documented under Section 2620.7.

36. It was not established that, on or about March 19, 1998, respondent failed to prepare a discharge summary indicating whether the patient or physical therapy met the treatment goals. The patient chart contains a typed report entitled, "Progress Report", and dated March 16, 1998, which was signed by respondent. Said progress report states that patient BW's back tenderness and spasms were decreasing but that the patient had pain between treatments. In said report, respondent noted what treatments the patient tolerated and was unable to perform. Respondent recommended re-examination by the physician and continuation of physical therapy. Said progress report constituted a discharge summary and adequately documented and summarized the treatment of the patient.

PATIENT HC

37. (A) On January 10, 2000, patient HC presented to Academy Rehabilitation for an initial evaluation and the start of physical therapy after suffering injuries in an automobile accident. Patient HC complained pain and stiffness in his neck and upper back; the patient indicated that he had constant pain in his anterior chest and shoulder which was exacerbated on deep inhalation or breathing. As described in her initial evaluation report, respondent noted that the patient held his neck and shoulder stiffly, measured the pertinent ranges of motion, and conducted strength tests. The test of strength of patient's shoulder was limited by pain. On palpation, respondent found tenderness. Respondent set the treatment goals as decrease pain, inflammation, and muscle spasms; increase range of motion; and restore pain-

free activities of daily living. The treatment plan consisted of hot packs, ultrasound, manual therapy, soft tissue and gentle joint mobilization, and medical exercise therapy.

(B) On January 10, 2000, respondent documented her initial evaluation of patient HC in the chart. However, respondent did not adequately document her evaluation or treatment goals. She noted that the goals for physical therapy included the decrease of pain and inflammation and the increase of the range of motion and functions. While she measured the patient's range of motion for his neck and back and noted the patient's activities, respondent failed to note an objective or subjective measurement or scale of the patient's level of pain that existed at the time of the initial evaluation. As such, respondent's documentation of the initial evaluation and treatment goals for patient CG was not complete.

38. During the course of thirteen sessions beginning on January 10, 2000, and continuing until March 17, 2000, respondent provided physical therapy services and treatment to patient HC according to the treatment plan. Respondent wrote progress notes reflecting the treatment modalities provided the patient. However, respondent did not specifically describe in the progress notes the frequency, duration, and intensity of the therapies provided to patient HC and did not note the responses of the patient to the therapies. As such, respondent's progress notes for patient HC's physical therapy sessions were not complete and respondent did not adequately document the treatment plan and summary of treatment in the patient's chart or record.

39. Based on Findings 37 – 38 above, respondent's failure to note measurements of pain at patient HC's initial visit rendered the initial evaluation report to be incomplete and the initial evaluation inadequately documented under Business and Professions Code Section 2620.7. Her failures to document the frequency, duration, or intensity of therapies administered to the patient HC or the patient's responses to the therapy likewise rendered her progress record to be incomplete and the treatment inadequately documented under Section 2620.7.

PATIENT HZ

40. (A) On July 12, 2000, patient HZ was prescribed physical therapy twice weekly for three weeks for treatment of a cervical strain. On July 17, patient HZ presented to respondent at Academy Rehabilitation and complained of bilateral neck and posterior shoulder pain as well as mid back pain and numbness. Respondent conducted an initial evaluation during which she observed that the patient's left shoulder was elevated by one-half inch and found tenderness and spasm on palpation. Respondent performed range of motion and strength tests. Patient HZ reported that all of her activities of daily living were limited by the neck and back pain. Respondent determined that the goals of physical therapy would be to decrease the spasms and pain and increase the patient's range of motion and functions. Respondent also made a treatment plan which consisted of hot packs, ultrasound, soft tissue and joint mobilization, medical exercise, kinetic activities, and work on the activities of daily living.

(B) On July 17, 2000, respondent took notes from and wrote her initial evaluation of patient HZ. However, respondent did not adequately document her evaluation or treatment goals. She noted that the goals for physical therapy were to decrease spasms and pain and to increase of the range of motion and functions. While she took pertinent measurements of patient's range of motion and noted how patient's activities were limited by the cervical sprain, respondent failed to note an objective or subjective measurement or scale of the patient's level of pain that existed at the time of the initial evaluation. As such, respondent's documentation of the initial evaluation and treatment goals for patient HZ was not complete.

41. (A) After conducting the initial evaluation on July 17 and performing physical therapy on the patient that same day, respondent saw patient HZ for 27 more sessions ending on October 16, 2000. For the 28 total sessions, respondent provided physical therapy to patient HZ pursuant to the treatment plan and noted the treatment modalities in the patient's chart. However, respondent did not specifically describe in the progress notes the frequency, duration, and intensity of the therapies provided to patient HZ and did not note the responses of the patient to the therapies. As such, respondent's progress notes for patient HZ"s physical therapy sessions were not complete and respondent did not adequately document the treatment plan and summary of treatment in the patient's chart or record.

(B) It was not established that respondent failed to document a summary of treatment or to prepare a discharge summary for patient HZ. On October 16, 2000, respondent prepared a progress update in which she summarized the patient's course of treatment from physical therapy. The progress update referenced the patient's initial complaints and deficits and described improvements from the therapy. Respondent noted that the patient was free of spasms and tenderness, had a full range of motion, and returned to daily exercise. Respondent recommended the patient be discharged from therapy. Said progress update thus constituted an adequate discharge summary.

42. Based on Findings 40 – 41 above, respondent's failure to note any measurements of pain at patient HZ's initial visit rendered the initial evaluation report to be incomplete and the initial evaluation inadequately documented under Business and Professions Code Section 2620.7. Her failures to document the frequency, duration, or intensity of therapies administered to the patient HZ or the patient's responses to the therapy likewise rendered her progress record to be incomplete and the treatment inadequately documented under Section 2620.7.

43. (A) Between July 17 and October 16, 2000, respondent saw and treated patient HZ for a total of 28 sessions. In other words, respondent provided physical therapy to the patient on 28 sessions over three months or about nine sessions per month. On July 12, the patient's referring physician initially prescribed physical therapy for three weeks at a frequency of twice weekly. At the initial evaluation, respondent prepared a treatment plan. Subsequently, respondent provided the same physical therapy modalities past the initial three

week prescription and for another two months without conducting re-evaluation of the patient and without consulting with the referring physician.

(B) It was not established that respondent provided "repeated acts of clearly excessive" administering of treatment to patient HZ in violation of Business and Professions Code Section 725. While patient was treated for 28 sessions, the course of physical therapy occurred over three months and therefore the frequency of the sessions was not excessively high. Further, no evidence was presented that the therapies provided by respondent were clearly excessive rather than reasonable and necessary for the patient. Complainant's expert criticized respondent for not conducting a re-evaluation of the patient after the first four weeks of therapy and not obtaining authorization from the physician for additional sessions but evidence of the governing standard of care for the community of licensees regarding whether the physical therapy was clearly excessive in this case was insufficient.

44. It was not established that respondent committed gross negligence in her practice as a physical therapist by providing excessive treatment to patient HZ without a treatment plan, by failing to document the course of treatment, and by failing to provide the patient's chart and billing information to the patient's attorney. First, respondent developed a treatment plan for the patient at the initial evaluation and provided physical therapy to the patient in accordance with the treatment plan. Second, it was not established why respondent's inadequate documentation of the course of treatment would constitute a departure from the standard of care in the case of patient HZ but would not in cases of the physical therapy records of the other patients in this matter. Third, while the failure to timely forward medical records to the attorney due to an unpaid bill and the attorney's lack of civility may have been a violation of the Health and Safety Code and a result of poor judgment, it was not established that such failure was necessarily a departure from the standard of care governing the practice of physical therapists. Besides, it was respondent's husband who handled this administrative matter and the attorney did eventually receive the medical records. Complainant failed to present sufficient evidence of the governing standard of care.

OTHER MATTERS

45. While she has employed or used physical therapy aides in her practice at Academy Rehabilitation, respondent recognizes and abides by her professional responsibility to supervise the aides while they provide patient related tasks. She has a custom or practice of supervising the aides to ensure that therapy is provided in a safe manner. During the time period at issue in this matter, respondent was late in entering progress notes in the patients' charts because she had lost the lease for her office and clinic and was using and sharing space in three different offices. She had a difficult time in keeping track of patient files. Respondent no longer has these administrative problems because she has settled in at her current offices for the past two or three years now.

46. Since the review of her patient files in July 2001, respondent has developed an office form to track which treatment modalities have been authorized to be performed by the

physical therapy aide. She closely supervises her single aide and makes sure that the aide signs the progress note after providing physical therapy. Respondent is more cognizant and careful of proper documentation of evaluations and treatment in the patients' charts. She has her evaluations typed and signs the typed evaluations for placement in the charts or for mailing to other health care providers. Respondent has also recently taken continuing education courses in billing and record-keeping.

47. The reasonable costs of investigation and enforcement of this matter come to the total sum of $13,744.00, as described in the declarations or certifications of costs. The costs of enforcement was $4,464, as set forth in the declaration of the deputy attorney general [Exh. 3], and the costs of investigation was $9,180, as set forth in the revised certification of investigative costs [Exh. 25].

* * * * * * *

Based on the foregoing findings of fact, the Administrative Law Judge makes the following determination of issues:

LEGAL CONCLUSIONS

1. Grounds exist to revoke or suspend respondent's license pursuant to Business and Professions Code Section 2660(j) and (k) in that respondent aided or abetted a person to violate the Physical Therapy Practice Act or to engage in the unlawful practice of physical therapy with respect to the single patient LT, as set forth in Finding 10 above.

2. Grounds also exist to revoke or suspend respondent's license pursuant to Business and Professions Code Section 2660(i) in that respondent violated a provision of the Physical Therapy Practice Act by failing to document her evaluation, goals, treatment plans, and summaries of treatment in the patient records of several patients as required by Business and Professions Code Section 2620.7, as set forth in Findings 7(C), 18, 21, 24, 27, 30, 35, 39, and 42 above.

3. Grounds also exist to revoke or suspend respondent's license pursuant to Business and Professions Code Section 2660(l) in that respondent committed fraudulent, dishonest, or corrupt acts in her care and treatment of a patient or record-keeping of such care and treatment which acts were substantially related to the qualifications, functions, or duties of a licensed physical therapist, as set forth in Finding 11(D) above.

4. Grounds do not exist to revoke or suspend respondent's license pursuant to Business and Professions Code Section 2660(h) in that it was not established that respondent

committed gross negligence in her practice as a physical therapist with respect to one patient, as set forth in Finding 44 above.

5. Grounds do not exist to revoke or suspend respondent's license pursuant to Business and Professions Code Section 725 in that it was not established that respondent committed repeated acts of clearly excessive administering of treatment with respect to a patient as determined by the standard of the community of licensed physical therapists, as set forth in Finding 43(B) above.

6. Grounds exist to revoke or suspend respondent's license pursuant to Business and Professions Code Section 2660 in that respondent committed unprofessional conduct, as set forth in Conclusions of Law nos. 1 – 3 above. Respondent's aiding and abetting of the unlicensed practice of physical therapy and her failures to adequately document the initial evaluations and course of physical therapy for several patients in this matter constituted unprofessional conduct.

7. Grounds exist to direct respondent to pay the Board for the reasonable costs of investigation and enforcement in this matter pursuant to Business and Professions Code Section 2661.5 in that respondent committed violations of the Physical Therapy Practice Act, based on Conclusions of Law nos. 1 – 6 above. The reasonable costs of investigation and enforcement of this matter are deemed to be $9,000.00, based on Finding 47 and Conclusions of Laws nos. 1 – 6 above. Said costs are reduced because complainant did not establish all of the allegations of the accusation.

8. Discussion—In this matter, the more serious violations concerned respondent's failure to supervise her physical therapy aide such that the aide engaged in the unlicensed practice of physical therapy as well as respondent's alteration of patient records. These violations involved the care and treatment of the single patient LT. Respondent's deficiencies in record-keeping under Business and Professions Code Section 2620.7 concerned several patients and were important in creating a complete record for the patients' care but were less serious in nature. There were mitigating factors to respondent's violations including her uncertain office situation which has been settled, her history of licensed practice without any discipline, and her increased awareness of proper record-keeping and supervision of aides. As such, a three-year period of probation with appropriate terms and conditions will suffice to continue to protect the public health and safety and to improve respondent's knowledge and practice as a physical therapist.

* * * * * * *

ORDER

First Amended Accusation, Case No. 1D-2000-62592, filed by the Physical Therapy Board of California against respondent Jane E. Savaheli, P.O. Box 491103, Los Angeles, California 90049, must be sustained and physical therapist's license no. PT-9186 previously issued to respondent Jane E. Savaheli shall be revoked, based on Conclusions of Law nos. 1 – 3, jointly and for all; provided, however, said order of revocation will be stayed and respondent's license placed on probation for three years on the following terms and conditions of probation:

1. The respondent's license shall be revoked, with the revocation stayed.

2. Respondent will be ordered to reimburse the Board the actual and reasonable investigative and prosecutorial costs incurred by the Board. The respondent will normally be ordered to make the reimbursement within 30 days from the effective date of the decision unless the Board agrees in writing to payment by an installment plan. Failure to make the ordered reimbursement, or any agreed upon payment, may constitute a violation of the probation order.

3. Respondent shall obey all federal, state and local laws, and statutes and regulations governing the practice of physical therapy in California.

4. Respondent shall be in compliance with any valid order of a court. Being found in contempt of any court may constitute a violation of probation.

5. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

6. Respondent shall comply with the Board's probation monitoring program.

7. Respondent shall appear in person for interviews with the Board, or its designee, upon request at various intervals and with reasonable notice.

8. Respondent shall notify all present or future employers, if applicable, of the reason for and the terms and conditions of the probation by providing a copy of the accusation and the decision and order to the employer. The respondent shall obtain written confirmation from the employer that the documents were received. If the respondent changes, or obtains additional employment, the respondent shall provide the above notification to the employer and submit written employer confirmation to the Board within 10 days. The notification(s) shall include the name, address and phone number of the employer, and, if different, the name, address and phone number of the work location.

9. Respondent shall notify the Board, in writing, of any and all changes of name or address within ten days.

10. Respondent may not use aliases and shall be prohibited from using any name which is not his/her legally-recognized name or based upon a legal change of name.

11. If the respondent works less than 192 hours in a period of three months, those months shall not be counted toward satisfaction of the probationary period. The respondent shall notify the Board if they work less than 192 hours in a three month period.

12. The period of probation shall run only during the time respondent is practicing within the jurisdiction of California. If, during probation, respondent does not practice within the jurisdiction of California, respondent is required to immediately notify the probation monitor in writing of the date that respondent's practice is out of state, and the date of return, if any. Practice by the respondent in California prior to notification to the Board of the respondents return will not be credited toward completion of probation. Any order for payment of cost recovery shall remain in effect whether or not probation is tolled.

13. If respondent violates probation in any respect, the Board, after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

14. Following the effective date of this probation, if respondent ceases practicing physical therapy due to retirement, health or other reasons respondent may request to surrender his/her license to the Board. The Board reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, the terms and conditions of probation shall be tolled until such time as the license is no longer renewable, the respondent makes application for the renewal of the tendered license or makes application for a new license.

15. Upon successful completion of probation, respondent's license or approval shall be fully restored.

16. It is not contrary to the public interest for the respondent to practice physical therapy under the probationary conditions specified in the disciplinary order.

17. Within thirty (30) days of the effective date of this Decision, respondent shall submit to the Board, or its designee, for prior approval a physical therapy remedial educational program, including any courses in record-keeping and ethics which may be designated by the Board, which shall not be less than twenty (20) hours. Following the completion of the program, the Board or its designee may administer an examination to test respondent’s competency or to demonstrate competency of the subject matter.

18. All costs incurred by the Board for probation monitoring during the entire period of probation shall be reimbursed by respondent. Respondent will be billed at least quarterly. Failure to make the ordered reimbursement within sixty (60) days of the billing shall constitute a violation of this probation order.

Dated: April 9, 2004

Original Signed By:
Vincent Nafarrete
Administrative Law Judge
Office of Administrative Hearings